Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

EDWIN J TAEGEL MD
10109 MCKKALLA PLACE STE E
AUSTIN TX 78758

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-13-1019-01

MFDR Date Received
December 27, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The enclosed claim was denied in error. This claim was for a Division ordered Designated Doctor Re-Exam. We billed a total of $950.00 for this claim but were paid nothing. The explanation given on the EOB justifying the denial states: *WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT*, however, this is incorrect. The reduction of parts of this claim is in violation of the rules of the Texas Department of Insurance Division of Workers' Compensation as this services was ordered on the DWC-32.

Therefore, please issue a payment promptly in the amount of $950.00 to settle this claim."

Amount in Dispute: $950.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor's request for reconsideration did not address the denial reason. And the requestor submitted a bill with different information in Box 31. (Attachment 3) This bill does not have 208D00000X instead there is only "OPHI." One could argue the request is not a true one because of the changed data. Nevertheless, Texas Mutual did review the bill, found no pertinent correction to the licensing information in BOX 31 and maintained the original denial of payment. Thus, no payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 15, 2012	CPT Code 99456-W5-WP	$950.00	$950.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code§134.204 sets out the fee guideline for workers' compensation specific services

on or after March 1, 2008.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated October 19, 2012

   - CAC-W1 – WORKERS COMPESATION STATE FEE SCHEDULE ADJUSTMENT
   - 892 – DENIED IN ACCORDANCE WITH DWC RULES AND/OR MEDICAL FEE GUIDELINE INCLUDING CURRENT CPT CODE DESCRIPTIONS/INSTRUCTIONS

   Explanation of benefits dated November 30, 2012

   - CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
   - CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY
   - 891 – NO ADDITIONAL PAYMENT AFTER RECONSIDERATION
   - 892 – DENIED IN ACCORDANCE WITH DWC RULES AND/OR MEDICAL FEE GUIDELINE INCLUDING CURRENT CPT CODE DESCRPTIONS/INSTRUCTIONS

Issues

1. Is the disputed services billed in accordance with 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

Findings

1. Review of the medical bills in dispute the requestor billed with CPT Code 99456-W5-WP for an amount of $350.00 with one unit billed, CPT Code 99456-W5-WP for an amount of $450.00 with two units billed and CPT Code 99456-W5-WP in the amount of $150.00 with one unit billed with a total amount of charges of $950.00

   Per 28 Texas Administrative Code §134.204 states: "(j) Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows, (1) The total MAR for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR, (3) The following applies for billing and reimbursement of an MMI evaluation, (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350, (4) The following applies for billing and reimbursement of an IR evaluation, (A) The HCP shall include billing components of the IR evaluation with the applicable MMI evaluation CPT code. The number of body areas rated shall be indicated in the units column of the billing form, (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas, (i) Musculoskeletal body areas are defined as follows, (I) spine and pelvis; (II) upper extremities and hands; and, (III) lower extremities (including feet), (ii) The MAR for musculoskeletal body areas shall be as follows, (I) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used, (II) If full physical evaluation, with range of motion, is performed: (-a-) $300 for the first musculoskeletal body area; and (-b-) $150 for each additional musculoskeletal body area.

   Therefore, CPT Code 99456-W5-WP is supported as the submitted documentation does indicate that a examination for Maximum Medical Improvement (MMI) and Impairment Rating (IR) to 3 body areas being performed using range of motion for two areas and one area using Diagnosis Related Estimate (DRE) method.

   The total MAR for CPT Code 99456-W5-WP is $950.00

2. The respondent issued payment in the amount of $0.00. Based upon the documentation submitted, additional reimbursement in the amount of $950.00 is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $950.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		March 07, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.